

SUFFOLK PLASTIC SURGEONS, P.C.

(631)751-4400

179 Belle Meade Road, Suite 1 E. Setauket, NY 11733
Patient Information as of _____ (enter today's date)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Any restrictions for contacting you
at home or work? No Yes E-mail _____

Age _____ Birthdate ____/____/____ SS# ____-____-____ Sex Female Male

Marital Status Single Married to: _____ Referring Doctor _____

Allergies _____

Patient's Employer _____ Occupation _____

Address _____
Street & Suite # City State Zip

Primary Health Insurance Company _____

Address: _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____ Ins SS#: _____

Insured: Name _____ **Date of Birth** _____ Employer _____

Secondary Health Insurance Company _____

Address: _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____ Ins SS#: _____

Insured: Name _____ DOB _____ Employer _____

Responsible Party _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

I hereby authorize any physician, health care practitioner, hospital, medical related facility, insurance company, or consumer Reporting agency to furnish any and all records, photographs, medical history, services rendered, or treatment given to myself Or any dependent for the purpose of review, investigation, or evaluation of any claim submitted to insurer.

If there is a default in the payment of any sums due, I agree that I will additionally pay reasonable attorney's fees, collection and court costs. I request that payment of the authorized insurance benefits be paid on my behalf to Hilton C. Adler, M.D., Stephen F. Coccaro, M.D., or to Kenneth C. Kneessy, M.D., for any services rendered by this office.

Signature _____ **Date** _____

Relationship to patient _____ **Date** _____